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ABSTRACT

This study makes available to nurses and other rehabilitation team members pertinent information to meet stroke patients' educational needs. The study was conducted to support the theory that those patients and families who actively participate in a stroke education program will more positively cope with the losses resulting from the disability than those persons who allow the event to overwhelm them. The information and recommendations provided to health professionals by this study are intended to establish and improve stroke rehabilitation health curricula in medical facilities. An introductory section defines the problem, explains the significance, organization and limitations of the study, and provides a list of definitions of terms used. Bibliographic annotations are grouped under the following categories: (1) stroke medical care--assessment and treatment; (2) stroke curriculum--holistic needs and specific needs; (3) patient education--patient teaching and teaching guides; and (4) educational program implementation--non-stroke programs and stroke programs. A summary of findings is provided and conclusion and recommendations are offered. (JD)

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"AN ANNOTATED BIBLIOGRAPHY OF CURRENT LITERATURE DEALING WITH STROKE EDUCATION PROGRAMS IN A PHYSICAL REHABILITATION SETTING"

BY

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by

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Submitted in partial fulfillment of the requirements
of the course S591 - Exit Project
Indiana University at South Bend
November, 1986

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I wish to thank the following people who have helped me to become the person I am today.

Zoe - who has creatively and professionally guided and gently pushed me during our friendship,

David - who has taught me patience and understanding,

Claire, Mary, Dan and Joe - who have always supported and loved me,

My mother - who has instilled the confidence in me to keep pursuing my goals,

and

My grandmother - who nurtured me and showed me how to live and die with dignity

INTRODUCTION

One in ten American families is somehow touched by stroke. Also, victims of initial and second or further strokes in the United States total more than 640,000 a year. Many strokes are fatal, but most are not. In fact, although stroke is the third greatest disease-related killer in the United States, behind cancer and heart disease, the death rate from stroke has been falling for more than a decade - for instance, from 214,000 in 1973 to 170,000 in 1980. As a result, the number of Americans who have survived stroke is now estimated as high as almost three million. (National Stroke Association) With this occurrence is an increased need for physical rehabilitation for stroke victims.

For patients and their families a stroke can be an overwhelming event. (Dunn, Nelson and Peterson: 27) Patients become challenged to learn new ways to communicate, to carry out routine hygienic activities, to dress, to be mobile in a wheelchair or with ambulation equipment and to feed themselves. In addition, these new activities must be learned by patients who are (usually) old and previously affected with other chronic conditions, such as arthritis, heart disease, or hypertension. (Dunn, Nelson and Peterson: 27)

For rehabilitation to be effective, the family and patient must be involved. Members should be properly informed so that they have reasonable expectations of the patient and of themselves. (Dunn, Nelson and Peterson: 27) The impact of a disability affects not only the lives of the people who bear the impairments, but also the members of their families, friends, co-workers, and others. A United Nations expert group has estimated that at least twenty-five percent of any population are people whose lives are influenced by disability, whose time and energy are to some degree involved with the requirements of people who are impaired. (Acton: 146)

Positive approaches, such as a stroke family education program, are necessary to enhance the effectiveness of rehabilitation attempts with stroke victims. (Kisly: 64) Strokes are a catastrophic illness that not only have medical and physical components, but social and psychological components which ultimately influence the patient's optimal functioning. (Kisly: 64, 66)

Programs can achieve improved patient participation and motivation toward recovery by enlisting the patient's innate drive toward health and through the assistance of families. They can help to relieve the patient and his family of unnecessary stress. Consequently, an increased amount of mental energy is made for recovery and adjustment to reality. (Kisly: 72) She believed that her stroke program and others related to other diagnostic categories have served their purpose in attempting to meet some universal needs of patients with disabling diseases. These educational and supportive programs are attempts to dispel myths about disabilties. They use the basic principle that positive attitudes are based on constructive views of life with a disability and to acquire those views requires being exposed to those views through information and direct experience. (B. Wright: 274)

STATEMENT OF THE PROBLEM

There is a definite need for increased information by stroke patients and their families. They have to learn to adjust to the losses that are associated with their newly acquired condition, such as independence and function. Participation of both parties is critical for stroke victims to achieve their optimal level of independence. Through a stroke education program at a rehabilitation center, family involvement may be increased, anxiety related to previous misconceptions about strokes reduced, and levels of independence by the patient maintained or increased. There is no established comprehensive program to meet the educational and psychosocial needs of stroke patients.

SIGNIFICANCE OF THE STUDY

The significance of the study was to make available to nurses and other rehabilitation team members pertinent information to meet stroke patients' educational needs. This study was conducted to support the theory that those patients and families who actively participate in a stroke education program will more positively cope with the losses resulting from the disability than those persons who allow the event to overwhelm them. The information and recommendations provided to health professionals by this study are intended to establish and improve stroke rehabilitation health curricula in medical facilities.

ORGANIZATION OF THE STUDY

The stroke material was divided into four major sections. Some of the topics overlapped, but the main ideas were identified and categorized into the most appropriate subdivisions. First, the study was concerned with the nomenclature related to strokes. It included assessment and treatment modalities. In the next section, a stroke curriculum was described. This topic was further divided into holistic and specific needs of stroke patients. Information related to patient instruction followed. This was classified into either patient teaching or teaching guides. Lastly, approaches to the development and implementation of supportive stroke and non-stroke education programs were discussed.

LIMITATIONS OF THE STUDY

One limitation of the study was that there were more opinion papers than research studies that identified the needs of stroke patients. Another factor was that there were few tools available to provide teaching to brain damaged individuals. Likewise, there was little written on how to measure the effectiveness of the teaching. Most limiting, however, was the fact that there were only two particular articles that detailed structured educational and supportive stroke groups. Thus, this study can only stress the need for stroke educational programs, but not until more formal groups begin, can they be evaluated for effectiveness.

DEFINITION OF TERMS

Assessment - (to systematically) determine the importance, size, and value of (a patient's status). (Webster: 109)

Disability - any physical, mental or emotional condition that is chronic or long-lasting (not acute or temporary), which is severe enough to limit the individual's functioning, and which results in, or threatens to be a handicap to productive activity. (G. Wright: 9)

Family - a group of persons usually of common ancestry, but may be an individual or group of individuals (who is/are a basic nurturing and supportive unit for another). (Webster: 448)

Holistic Need - In philosophic assumptions of rehabilitation it is to meet the requirements for the whole (G. Wright: 6)) well-being of an organism. (Webster: 790)

Interdisciplinary-Multidisciplinary Team Members - includes the patient, the family, nurses, physical therapists, (neuropsychologists, psychiatrists, recreational therapists), and others as needed. (Dunn, Nelson, Peterson: 27)

Learning - a change in behavior: in a concept, an attitude or a skill. (Stryker: 104)

Non-Stroke Education Program - an educational program related to a medical condition other than stroke.

Patient-Client - (an individual who is the recipient (consumer)of nursing care) whose purpose is self actualization and who is the most important member of the rehabilitation team. (Rehabilitation Nursing Institute: 297)

Patient Education - a process of informing patients and their families about the illness, treatment, and other health related matters, including how to adhere to their regimen, and helping them change their behavior. (Miller: 301)

Patient Teaching - A three-step approach that requires:

(a) establishing rapport and reducing anxiety and fear,

(b) teaching patients about their illness, treatment plan, and other health matters, and

(c) overcoming obstacles to behavior change.

(Miller: 301)

Physical Rehabilitation Setting - an environment (Webster: 1077) (that is conducive for caring for spinal cord, closed head injury, amputation, cerebrovascular accident and other neurologically disabled patients).

Rehabilitation - the restoration of the individual to the fullest physical, mental, social, vocational and economic capacity of which the individual is capable. (Stryker: 13)

Rehabilitation nurse - a person who provides nursing care directed toward prevention, maintenance, and/or restoration of function of the effects of disability with a goal of patient's adaption to an altered lifestyle. (Rehabilitation Nursing Institute: 298)

Specific Need - (a restricted) (Webster: 1132) physiological or psychological requirement for the well-being of an organism. (Webster: 790)

Stroke-Cerebrovascular Accident - C.V.A. - a sudden, often severe, disability of the body brought on by a disruption in the flow of the blood to the brain. (National Stroke Association)

Stroke Education Program - the purpose of this program is to (1) serve as an educational medium, and (2) provide a supportive experience. Its aim is to help patients and their families find constructive ways to deal with the physical, psychological, and social compenents of stroke. (Kisly: 64)

Teaching Guide - a way or course that directs, supervises, or influences (Webster: 541) a manner of imparting information or skill so that others may learn. (Webster: 1209)

Treatment - the techniques or actions customarily applied in a specified situation (Webster: 1257) (such as the medical and nursing management of stroke patients).

BACKGROUND INFORMATION

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III. Indiana University at South Bend
Major: Masters of Science in Education Candidate, December 1986

Memorial Hospital School of Nursing of South Bend, Indiana
Diploma: Nursing, December 1984

Purdue University, West Lafayette, Indiana
Major: Bachelor of Arts in Psychology, May 1981

IV. February 1985 - present: Registered Nurse, I
Michiana Rehabilitation Institute of Memorial Hospital of South Bend (MRI)

December 1984 - present: Registered Nurse, Memorial Staffing Services

June 1982 - December 1984: Clinical Associate II and III,
Memorial Hospital of South Bend

V. Rehabilitation Staff - Charge Nurse working exclusively with stroke and closed head injury patients and participating in weekly interdisciplinary team meetings in planning their care.

Developer of comprehensive stroke and amputation protocals for Michiana Rehabilitation Institute (MRI).

Co-Presenter of "Computerized Nursing Diagnoses" at National ARN Conference, November 1986

Chairperson of MRI Stroke Education Program Committee

Preceptor for general orientation of rehabilitation nurses

VI. Member of: Nursing Research Steering Committee, Local and National Stroke Association, Association of Rehabilitation Nurses (ARN), Northern Indiana Nursing Research Consortium, and Memorial Nursing Alumni Organization

VII. Interest stems from Michiana Rehabilitation's desire to establish a structured stroke educational program for patients and families.

STROKE MEDICAL CARE

Assessment

Burt, Margaret M., "Perceptual Deficits in Hemiplegia". American Journal of Nursing (May 1970): 1026-1029.

In this article, Burt identified perceptual problems experienced by stroke victims. Perception was defined as the ability to integrate and interpret all the sensory messages from our internal and external environment. Approaches that nurses can combine when dealing with the problem of neglect of the affected side were explained. Other methods to increase the patients' awareness of their deficits were listed. Eating, dressing, positioning, scanning, time passage, and learning were addressed. This article was important because it realistically gave suggestions to nurses who attempt to help stroke patients cope with their perceptual deficits. It gave some insight into the problems and awareness of some techniques which might help compensate for them.

Delisa, Joel A., Robert M. Miller, Rosalie R. Melnick and Mary A. Mikulic. "Stroke Rehabilitation: Part I, Cognitive Deficits and Prediction of Outcome". American Family Practice 26 (November 1982): 206-214.

The authors suggested that family physicians are important in the future of rehabilitation. They noted that if physicians understand the recovery and rehabilitation processes more, then they can provide appropriate counseling to patients and families and to make appropriate referrals. This article was limited to the discussion of cortical damage from middle cerebral artery thromboembolism. Strokes resulting from involvement of other sites or etiologies were not discussed. Emphasis was placed on the outcomes that can be expected from the rehabilitation process and on the selection of patients for a comprehensive rehabilitation program. They believed that all stroke patients with any deficits should undergo an evaluation, although an intensive multidisciplinary team approach was not always effective in some cases. They listed predictors that were associated with unfavorable outcomes after a stroke. In addition, it was found that if family members are available to help or if other support can be obtained, it was more likely that the patient will return home rather than be institutionalized. It was stressed that persons on a rehabilitation team can provide valuable management suggestions to the physician and family members.

Gresham, Glen E., "Rehabilitation of the Geriatric Patient - Stroke Rehabilitation, the Rehabilitation Team, and the Usefulness of Functional Assessment". Primary Care 9 (March 1982): 239-247.

This was a case history that pointed out important features of geriatric rehabilitation. Gresham combined the medical rehabilitation purpose of functional enhancement with the geriatric medicine goal of maximizing the independence and quality of life of the older person. He stressed that a multidisciplinary team approach be used in both settings. Then, goals towards functional restoration after illness or injury, orientation toward functional preservation care of the elderly, and the use of systematic functional assessment as a method of monitoring and documenting were discussed. An example of an elderly stroke survivor was used because stroke had both a high frequency of occurrence and a positive association with advancing age. Salient features that were included were: work decreased, socialization within and outside the home decreased, household tasks became limited, interests and hobbies decreased, transportation became difficult, activities of daily living became dependent, mobility became dependent, and institutional living more likely required.

Louis, Maura Cryan and Susan M. Povse, "Aphasia and Endurance:Considerations in the Assessment and Care of the Stroke Patient". Nursing Clinics of North America 15 (June 1980): 265-282.

This article, which was presented at a symposium on rehabilitation nursing, concentrated on two major factors that influence the rehabilitation of the stroke patient. Background information, parameters of assessment, and pertinent patient care measures related to aphasia and endurance were addressed. This article helped identify the educational and supportive needs of the patients and of their families.

Piotrowski, Marcia M., "Body Image After a Stroke". Rehabilitation Nursing (January - February 1982): 11-13.

Piotrowski, in this article introduced the idea of body image and its relationship to stroke patients. She related the importance of body image and rehabilitation. It was argued that in the concern over promoting self-care skills, that the images of patients may be overlooked. This article contained a review of the literature concerning body image. Next, the types of changes that alter images were defined as physical, perceptual, language, and personality. Implications for nursing were discussed. Lastly, it was emphasized that nurses must help patients not only gain strength and functional skills, but also gain comfortable and realistic pictures of themselves.

Williamson, Thomas E. Kirkland, and Rosemarian Berni, "Neurological Aspects of Rehabilitation Part 1: Brain Injury". ARN (May-June 1980): 12-12, 20.

This article was a basic informational paper for nurses. It was the first of a two paper series. It was important to realize that this paper was always used in conjunction with the designated illustration plates from the CIBA Collection of Medical Illustrators, Vol. I, The Nervous System (1962), illustrated by Frank M. Neller, M.D.. In particular, cerebral vascular accidents, traumatic brain injury and anoxic brain damage were described. It was suggested that this article could be used as a teaching tool with family and patients. Lastly, it was emphasized that the most important function of rehabilitation nurses was high quality patient/consumer and family teaching.

Zinn, W.M., "Assessment, Treatment and Rehabilitation of Adult Patients with Brain Damage". International Rehabilitation Medicine 1 (1978): 3-9.

Zinn described the assessment, treatment and rehabilitation of adult patients with brain damage. He listed statistics and defined populations traumatized with disabilities. He emphasized that full assessment of all functional disturbances caused by cerebrovascular accidents and brain injury was the first step to successful treatment and rehabilitation. Management in the early stage, the neurophysiology of regeneration after brain damage and therapeutic techniques were discussed. A formal rehabilitation with an informal network of reliable persons around the patient was encouraged. Studies concerning independence in daily living of a formal rehabilitation program were compared to a group of patients only treated in an acute hospital. Neuropsychological assessments and training were discussed as having possible value in treatment plans. Zinn argued that the use of standardized assessments could help evaluate reliable criteria for comparing patients from different rehabilitation units.

Bobath, Berta, "Treatment of Adult Hemiplegia". Physiotherapy 63 (October 1977): 310-313.

This article, written by the Director of Studies of the Bobath Centre in London, described how nurses can work with physical therapists to improve treatment of the stroke victim. She stressed that during the early stage of a patient's hospitalization emphasis should be placed on the use of the affected side. She described how stroke victims experience loss of movement patterns, sensory deficits, problems related to muscle paralysis or paresis, and abnormal postural tone. Assessment and treatment planning followed.

Delisa, Joel A., Mary A. Mikulic, Rosalie R. Melnick and Robert M. Miller. "Stroke Rehabilitation: Part II, Recovery and Complications". American Family Practice 26 (December 1982): 143-151.

It was noted that the return of neurologic function after a stroke tends to be complete within six months after the insult. The authors pointed out the natural recovery after this time is rare, although function may continue to improve with additional training. It was stressed that if staff and family are taught care, complications are prevented. Lastly, considerations for discharge planning were discussed. The positive role of the family was pointed out. Members can benefit from special education about the effects of the stroke and the treatment approaches. Families should participate in therapy sessions to learn about the patient's progress, and the proper techniques for exercises, transfers, and ambulation. The sessions also help family members form a realistic view of further therapy. Trial passes allow the patient and family to adjust to the home setting gradually.

Hart, Geraldine, "Strokes Causing Left vs. Right Hemiplegia: Different Effects and Nursing Implications". Geriatric Nursing (January - February 1983): 39-43.

This article identified different assessments and nursing implications for left and right hemiplegia. Hart indicated that not every stroke victim has the same needs. In particular, seven functions were examined: language, speech, sensation (specifically, vision, pain, and position sense), perception (of self and environment), movement (hemiplegia and apraxia), behavioral style, and memory. A diagram of the brain was included, along with a summarized chart of the possible effects of stroke on the above seven functions. Lastly, an insert of a narrative of a stroke victim was included. His concluding advice for stroke victims was to work hard, set goals, be encouraged by any progress and maintain a positive attitude. He suggested that depressed thoughts be replaced with accomplishments.

Kaplan, Paul E. and Leonard J. Cerullo, Stroke Rehabilitation. Butterworth Publishers, Stoneham, Massachusetts, 1986.

This book was an outgrowth of a course at the Rehabilitation Institute of Chicago called Stroke and Neuro-Surgical Rehabilitation. It was representative of a typical rehabilitation team. The chapters were written by different professionals. They included such topics as: the clinical presentation of stroke syndromes, care of the patient with acute stroke, psychological and neuropsychological factors in stroke management, nursing therapy and stroke rehabilitation, and recovery from behavioral deficits after stroke.

Norman, Susan and Robin Baratz, "Understanding Aphasia "The Brain Damaged Patient - Approaches to Assessment, Care and Rehabilitation". American Journal of Nursing (December 1979): 2117, 2135-38.

This was the fourth article of a four part series on the brain-damaged patient. It was a continuing education offering of the American Journal of Nursing under the mechanism for accreditation of continuing education in nursing. The article covered these main objectives related to aphasia:

(a) Describe four types of aphasia based on the area of the brain that is damaged and how the disorder is manifested.

(b) Identify approaches to speaking and listening to patients with aphasia based on the nature of the existing language deficit.

Richardson, Karolee, "Right Brain-Left Brain: The Nurse Consultant and Behavior Change Following Stroke". JPNMHS (May 1982): 37-39.

This was the script for an inservice presentation regarding a general review of the brain. Information was given to the most frequently asked questions in a manner that Richardson found to be most useful to and understandable by all levels of staff nurses. She gave an overview of brain function and defined the hemispheric abilities. A table listed the different methods of processing information; for example, the left brain is identified with reason, symbols, directive, objective, successive, language, scheduled, planful, numbers and detail and the right brain with intuition, experience, free, subjective, simultaneous, picture, timeless, imaginative, patterns and whole. Diagnoses of hemispheric damage were described. In summary, Richardson made suggestions for working with staff to promote empathy for the stroke patient presenting with behavior problems.

Stryker, Ruth, "Patient and Family Learning - The Test of Teaching". In Rehabilitative Aspects of Acute and Chronic Nursing Care. Philadelphia: W.B. Saunders Company, 1977.

This book was designed for students and practitioners, but it can also be used as a faculty reference and may sometimes be useful to selected patients and families. It attempted to stimulate its readers, especially nurses, to incorporate appropriate preventive, maintenance and restorative measures in their patient care regardless of the setting in which they practice nursing. Specific chapters discussed the history and concepts of rehabilitation. Also, an overview of rehabilitation nursing was present. Nursing care and nursing skill units followed. Included in the former unit was a chapter on patient and family learning. Lastly, the future of rehabilitation was discussed.

Tilton, Colette N. and Malcom Maloof, "Diagnosing the Problems in Stroke". American Journal of Nursing (April 1982): 596-601.

These authors used a case study to help identify nursing diagnoses that are related to the problems in stroke. The following are some of the nursing diagnoses that were identified:

(a) impairment in communication related to aphasia,
(b) sensory-preceptual alteration related to right-sided hemianopsia and hemiparesthesia,
(c) impaired physical mobility related to hemiplegia and hemiparesthesia on right,
(d) alteration in nutrition related to impaired swallowing and right sided hemiplegia,
(e) alteration in pattern of urinary elimination related to impaired impulse to void associated with neurogenic bladder,
(f) alteration in bowel elimination related to alteration in nutrition, immobility, and impaired defecation impulse, and
(g) potential impairment in skin integrity related to diminished sensation, impaired mobility, and incontinence.

Methods were then given for each problem. The authors stressed that the nomenclature of nursing diagnoses offers nurses a precise and consistent means of communicating and documenting the problems that nurses can manage.

Wallhagen, Margaret I., "The Split Brain: Implications for Care and Rehabilitation". American Journal of Nursing (December 1979): 2117-2138.

This was the first article of a four part series on the brain-damaged patient. It was a continuing education offering of the American Journal of Nursing under the mechanism for accreditation of continuing education in nursing. The article covered these main objectives:

(a) Describe the functions of the left and right hemispheres,
(b) Identify areas of the brain and their function,
(c) Make predictions about the behavior of brain damaged patients based on knowledge of research on the split brain phenomenon,
(d) Identify behaviors and deficits (characteristics) of patients with left and right hemispheric lesions,
(e) Describe signs and symptoms of patients with right hemispheric lesions,
(f) Plan care specific to patients with right hemispheric lesions and patients with left hemispheric lesions.

Wright, George Nelson, Total Rehabilitation. Little, Brown and Company, Boston, 1986.

This book covered the complex process of overcoming a handicap through comprehensive vocational and life adjustment services to disabled or disadvantaged individuals. Forty chapters were bound together in five major parts:

Foundations - overview and orientation
Resources - facilities and services
Assessment - client evaluation and planning
Counseling - adjustment areas and methods
Placement - employment techniques and alternatives

Essential information for rehabilitation practice was provided in the first two parts, while the last three parts described professional techniques. The chapters followed the steps of the rehabilitation process from case-finding to closure.

Rehabilitation Nursing Institute. Rehabilitation Nursing: Concepts and Practice. (Core Curriculum) (1981) 2506 Gross Point Road, Evanston, Illinois 60201. 1-312-475-7530.

This document was written for rehabilitation nurses by rehabilitation nurses. It was referred to as a Core Curriculum because it is the main knowledge base of rehabilitation nurses. It was a dual project of the Association of Rehabilitaiton Nurses and the Rehabilitation Nursing Institute.

The table of contents included the following:

The Concepts of Rehabilitation and Rehabilitation Nursing
The Conceptual Basis of Rehabilitation Nursing
The Practice of Rehabilitation Nursing and the Disabled Community

A second Core Curriculum is planned to be published by 1987.

Acton, Norman, "The World's Response to Disability: Evolution of a Philosophy". Archives Physical Medical Rehabilitation 63 (April 1982): 145-149.

This article was a major lecture at the 58th Annual Session of the American Congress of Rehabilitation Medicine. The author who was then Secretary General of Rehabilitation International hoped to demonstrate the gaps between the problems associated with impairment, disability and handicap and the inadequate character of the human response. He was hoping that with an increased understanding of the realities, a more adequate response would be generated. He stressed that the impact of a disability affects the people who bear the impairments as well as their families, friends, co-workers and others. A United Nations expert group estimated that at least 25% of any population are people whose lives are influenced by disability. Revisions or suggestions in the presently accepted approaches were:

(a) We should take the trouble to supply information and provide support to the greatest underemployed assets in the rehabilitation process, (i.e. impaired individual, his family and immediate community).

(b) Existing human service institutions, (i.e. general hospitals, clinics, and practitioners of general or related disciplines, schools, vocational training programs, social service and security systems and community development projects), need to organize and link up with the more formal rehabilitation effort.

(c) We should understand that to have the individual independent and fully participating, that the tasks to help them reach these goals should be shared by a much larger base of people and institutions.

He ended by challenging his readers:

(a) To keep extending miracles to all who need them, and

(b) To enlighten those people with distorted and retarded attitudes so that the successes of rehabilitation professions will not be overlooked because of prejudice, discrimination and apathy.

Carlson, Carolyn E., "Psychosocial Aspects of Neurologic Disability". Nursing Clinics of North America 15 (June 1980): 309-320.

At a symposium Carlson highlighted some of the factors that contribute to the uniqueness of the psychosocial aspects of neurologic conditions. She also discussed some of the common characteristics of the conditions that tend to have considerable psychosocial impact. The patient population included in the symposium focused on stroke, spinal cord injury, multiple sclerosis and the Guillian-Barre Syndrome. First, the concept of individual uniqueness was defined. Next a few consequences that occur frequently in persons with neurologic disabilities were listed. They were: changes in self-perception, visibility, pressure to mourn, becoming discredited, and spread (inferring one type of deficit or disability from another). Patterns of living and coping were addressed. Significant others were stressed as playing centrol roles in influencing the psychosocial consequences for neurologically disabled patients. Nursing interventions were included along with a discussion of goal setting related to self or social perceptions and behavioral patterns. In the nursing discussion were assessment and continuous evaluation measures. Lastly, the general goal of facilitating the patient to approximate premorbid psychosocial functioning was reitterated.

Chesterman, Lovella, "Stroke - A New Beginning?". Nursing Times 26 (September 1984): 40-44.

This article was a case study that described a stroke patient's needs and how they were met in a specialized rehabilitation unit. Chesterman detailed how a stroke is a catastrophic event in a person's life. For example, this was a story of a man in his late 40's who had a moderately severe stroke. He had very slight movement in his affected arm, and only little more in his leg. Immediately following the stroke one perspective reflected that he made an excellent recovery. He was eventually able to walk long distances with the aide of a walking stick and mastered his activities of daily living. However, as a man with a teenage family (a boy of fourteen and a girl of thirteen), a young attractive wife, and a job which he loved, his stroke came to him as a truly devastating event. Frustration, shame, doubt and alterations in his self esteem were social-psychological concerns. Resultingly, although the patient can cope with life independently in the community, the author argued that staff had failed in having him fully accept his disability suggesting that a job retraining program would have been of benefit to a more comprehensive acceptance.

Clark, Meryl, "Diary of a Stroke Victim". Nursing Times 24 (August 1983): 27-30.

Clark described her experience as a stroke victim in this article. Specifically, she identified needs from a personal perspective. Suggestions were cited to make the stroke patient feel more comfortable. For example, she was less frustrated when persons told her that they could not understand her as opposed to when they humored her and she ended up saying wrong answers. She discussed wanting to die during long and lonely nights, but her body, friends and family would not allow her. The progression of her recovery period was described. Lastly, she explained how frustrating the future is for her, but how grateful she is to be as independent as she has gotten.

Kottke, Frederic J., "Philosophic Considerations of Quality of Life for the Disabled". Archives of Physical Medical Rehabilitation 63 (February 1982): 60-62.

This paper was presented at the 56th Annual Session of the American Congress of Rehabilitation Medicine in November of 1979. Kottke began by noting that all of us are concerned with the length of our lives and also about having meaningful lives. In his presentation the quality of living, rather than longevity, was the major consideration. Kottke pointed out that disabled patients have a greater problem in achieving a satisfactory quality of life because they have lost, or possibly never had, the physical capacity for the necessary responses to establish and maintain the relationships, interactions, and participation that healthy persons have. Consequently, they are dependent upon the rehabilitation team to provide assistance and services to make it possible for them to achieve their optimal level of performance as the basis for the quality of their lives.

Makas, Elaine, "Increasing Counselor-Clinet Communication". Rehabilitation Literature 41 (September - October 1980): 235-238.

This article which was prepared with the support of a federal grant and the School of Education and Human Development at George Washington University stressed the need for effective communication between counselor and client as a necessary factor in cooperation. Various research studies were mentioned. Lastly, the importance of similarity between counselor and client demographic characteristics has been suggested, but not empirically measured. In addition, the relative importance of various counselor demographic characteristics has not been addressed in the current literature at all. The article concluded by recommending that a study be conducted in which clients are asked to indicate whether such counselor characteristics as race, disability, sex, and age, affect their initial feelings of rapport with a counselor, and the relative importance of each of these factors in establishing a cooperative rehabilitation environment.

Russell, Roger A., "Concepts of Adjustment to Disability: An Overview". Rehabilitation Literature 42 (November - December 1981): 330-338.

Russell described how a physical disability presents persons with a crisis calling for adjustment. He discussed this topic because the disability produces physical losses and changes. He reviewed the literature related to the various theoretical approaches and the ways in which they define adjustment to disability. Adaption, coping, mastery, and rehabilitation were the terms used mostly synonymously with adjustment. Person-oriented approaches were broken into behavioral and mental adjustment. Socio-environmental approaches were social constuction of reality, attitudes and labeling. Next an integrative approach was explained which saw adjustment as involving both persons and their milieu.

Steger, Herbert G., "Understanding the Psychologic Factors in Rehabilitation". Geriatrics (May 1976): 68-73.

This article which was funded by a federal grant was presented at a symposium. Steger emphasized that rehabilitation care requires a holistic approach to the patient. Also, psychological and social factors that influence patients, their disability and their rehabilitation were stressed as important. The understanding of rehabilitation psychological factors was important for two general reasons. First, the elderly patient is in a markedly different life-cycle period than younger patients. Secondly, rehabilitation is largely concerned with restoring optimal independent function and allowing patients to overcome or compensate for functional losses. Learning abilities of brain-damaged patients and non-brain damaged patients were described. This author's viewpoint was that difficulties encountered were the result of motivational, task, and performance factors rather than actual deficits in learning ability. A recommendation was made to maintain as much relevance as possible to the patient's daily life. This should insure greater involvement and better performance.

Wright, Beatrice A., "Developing Constructive Views of Life with a Disability". Rehabilitation Literature 41 (November - December 1980): 274-279.

This paper was an edited version of the opening address at the quadrennial meeting of the social commission - Rehabilitation International. Wright's purpose was to demonstrate a basic principle, namely, that positive attitudes are based on constructive views of life with a disability, and to acquire those views requires being exposed to those views through information and direct experience. Thirteen main ideas were stressed as follows:

(a) Positive attitudes will not thrive when the predominant focus is on disabling aspects of disability.

(b) Constructive views of life with a disability, conceptualized within the coping framework, provide an excellent basis for developing positive attitides.

(c) One example of a constructive view is that people with disabilites are not passive - they do and must actively take charge of their lives. They are highly differentiated as individuals.

(d) The severity of a disability is as much a function of physical and social environmental barriers, if not more so, then of personal impairment.

(e) Inclusion through reasonable accomodations widens opportunities for everybody and provides a strong counterforce against exclusion, discrimination, and prejudice.

(f) To influence attitudes positively, such constructive views must be conveyed through information and direct experience.

(g) In all attitude change attempts, the negatives associated with the disability of the person and with barriers in the environment must be placed within a positive context in order to counteract the distorting power of both negative spread effects and the just world phenomenon.

(h) The positive context consists of two major parts. One refers to the assets and abilities of the person with a disability; the other to the hidden resources and forces in families and the wider society that are there to be trapped and strengthened in the effort to bring about needed change.

(i) The positives must not remain hidden and neglected when problems are being emphasized.

(j) The thrust should be to seek solutions to problems, not to remain stuck with them.

(k) Competitive situations are not conducive to improving attitudes toward those who suffer by comparison. What is needed is a climate that values the intrinsic worth of people and their abilities, not their comparative standing.

(l) Attempts to change attitudes through simulating a disability in awareness training, through educational programs and direct contact with people with disabilities will benefit from the application of these principles.

(m) All service providers, researchers, and other professionsl must make use of these principles, for what they do and what they say greatly affect public attitudes as well as the lives of persons with disabilities.

Zola, Irving Kenneth, "Denial of Emotional Needs to People with Handicaps". Archives of Physical Medical Rehabilitation 63 (February 1982): 63-67.

Zola argued that most literature focuses on the issue of accessibility for those with physical handicaps or chronic diseases and not their emotional needs. He stressed that society needs to correct its dealings with people who have handicaps. It was pointed out that persons with disabilities spend much of their time in a continuing effort to reclaim what they have lost. For instance, the right to act sexy, get angry, and be vulnerable are three denied and impeded needs. Zola presented this topic at a plenary session entitled "The Quality of Life of the Individual with a Disability" at the 56th Annual Session of the American Congress of Rehabilitation Medicine.

Belcher, Sandra A., Michael R. Clowers, Aurora C. Cabanayan and Wilbert E. Fordyce, "Activity Patters of Married and Single Individuals After Stroke". Archives Physical Medical Rehabilitation 63 (July 1982): 308-312.

This was an exploratory study of the social leisure activity levels of married and single individuals after stroke. A total of forty-one married and thirty-two single persons participated. A behavioral frequency scale designed to help identify and document the range and scope of effective client change brought about by rehabilitation efforts was administered. Results indicated that single persons showed higher levels of participation in performing personal care, home management and social interaction activities. Both groups participated in social activities and recreational events outside the home. It was hypothesized by the authors that married persons participated less often in social interaction activities because they can rely on their spouses for social interaction. They concluded by admitting that many questions must be resolved before full confidence can be placed in activity pattern descriptions of the stroke population.

Bray, Grady P., Richard S. DeFrank and Terri L. Wolfe, "Sexual Functioning in Stroke Survivors". Archives Physical Medical Rehabilitation 62 (June 1981): 286-288.

The authors investigated the sexual interest, function and attitudes of thirty-five stroke patients (twenty-four men and eleven women) before and after their stroke. They conducted structured interviews to adminsiter a sexual history and function questionnaire. No significant changes in sexual interest or desire in either men or women were found. The test did indicate, however, that men experienced significant decrease in ability to achieve erection and to ejaculate and all of the five women who were premenopausal at the time of stroke reported major alterations in menses. Only one woman reported orgasm following stroke. Nineteen (79%) of the men and eight (73%) of the women reported sexual function to be of importance to themselves. Meanwhile, all of the men and eight (73%) of the women believed it to be of importance to others of their age. The findings from this small sample indicated that although the majority of stroke survivors maintain consistent levels of sexual desire and believe that sexual function is important, most will experience sexual dysfunction following stroke. The authors advised further investigation of the sexual problems in stroke survivors.

Cable, Elizabeth Palmer and Stanley P. Mayers, "Discharge Planning Effect on Length of Hospital Stay". Archives Physical Medical Rehabilitation 64 (February 1983): 57-60.

Cable and Mayers investigated the impact of discharge planning in three community hospitals. They compared the annual median length of stay by diagnosis for two years before and two years after the introduction of discharge planning. The four diagnoses studied were congestive heart failure, cerebrovascular accident (CVA), chronic obstructive pulmonary disease, and fractured hip. Cataracts or benign prostatic hypertrophy served as control diagnosis. The results indicated that with the onset of discharge planning, length of stay increased and decreased for some diagnoses at each hospital. Their research suggested that the impact of discharge planning was specific for diagnosis and, in particular, the length of stay of cerebrovascular accident patients decreased the most frequently.

Davidson, Alice Ware and Cathy Young, "Repatterning of Stroke Rehabilitation Clients Following Return to Life in the Community". Journal of Neuropsychological Nursing 17 (April 1985): 123-128.

This study's purpose was to learn more about the problems stroke patients experience after rehabilitation and how they perceive and interact with their environment. The study consisted of twenty-nine stroke victims (twelve male and seventeen female) who were all admitted to and discharged from the same interdisciplinary rehabilitation program of a large metropolitan medical center and who all returned to independent living situations within the community. Subjects were interviewed in their homes by investigators using a sixteen question interview form developed and pre-tested by the investigators. The forms were designed to determine the individual's evaluation of his/her ability to function since coming home as well as to explore social and psychological patterns. Findings indicated that nurses need to consider individual life patterns, current goals, and the resources and impediments of the home and community enviroment in planning interventions. Subjects wanted a challenging, but not overly stressful environment as most of their energy was consumed with completing activities of daily living. Complex planning and timing were necessary to continue a few pleasurable activities.

Davies, Ann D.M. and Maureen Peters, "Stresses of Hospitalization in the Elderly: Nurses' and Patients' Perceptions". Journal of Advanced Nursing 8 (1983): 99-105.

Davies investigated stress in a hospital setting. Twenty-five patients (ages seventy through ninety-three years) and their nurses were interviewed about the patient's perceived stresses during the first and third weeks of hospitalization. The ward was designed in a modern style and a "patient allocation" system of nursing care was in operation. Essentially, one nurse had primary responsibility for each patient. Results indicated that patients differed significantly from nurses on the sixteen-item stress scale. As groups, however, patients and nurses showed significant correlations between stress ratings over the items. The researchers interpreted this as a common sharing of stereotypes related to hospital situations. There was no significant relationship found between nurses' and patients' ratings of the overall stress being experienced by the patients. An analysis of stress items showed there to be significant differences between types of stress. There was the least discrepency between the patients and nurses concerning physical illness aspects and the most stressful impact being related to the hospital environment and routine. For example, while patients rated items such as toileting to increase in stress during their hospital stay, nurses rated the stress value as decreasing.

Evans, Ron L. and Lawrence K. Northwood, "Social Support Needs in Adjustment to Stroke". Archives Physical Medical Rehabilitation, 64 (February 1983): 61-65.

This study was conducted to see how social needs of stroke victims can affect social outcomes and adjustment. The findings showed a wide variation amongst patients. Evans and Northwood then evaluated how much these individual differences are a function of interpersonal needs for social contact after the rehabilitation process. Subjective needs for social relations were measured and compared with adjustment to stroke. Thirty-four males and fourteen females (forty-three to fifty-seven years) initially hospitalized on acute medical hospital wards after a stroke participated in this project. Eventually, they were transferred to a rehabilitation floor for an intensive program. A fifty-four item questionnaire measured three particular areas of behavior; expression and desire for inclusion, control, and affection. The researchers concluded that expression of social needs was related to disability adjustment and social support. Secondly, objective social support and subjective needs were related and may well be measures of the same phenomenon. It was recommended that by knowing social support needs, a counselor can help the family better communicate with its members.

Evans, Ron L. and Lawrence K. Northwood, "Social Support Needs in Adjustment to Stroke". Archives Physical Medical Rehabilitation 64 (February 1983): 61-65.

This research study was conducted to identify social needs of stroke patients. In particular Evans and Northwood attempted to define the subjective perception of social support. He pointed out three elements of the support system that are critical in responsiveness to stroke patients. They were as follows:

(a) Significant others to cope with emotional problems.
(b) People to assist with daily living tasks, and
(c) Persons who have access to information, finances and resources.

Thirty-five males and five females were interviewed one year after hospitalization for sudden onset of stroke. Results indicated that the relationship between adjustment to disability and congruent expression of interpersonal needs was significant. It was, therefore, concluded that perception of social needs being met was correlated with positive adjustment to physical limitations resulting from stroke.

Feibel, John M. and Carla J. Springer "Depression and Failure to Resume Social Activities After Stroke". Archives of Physical Medical Rehabilitation, 63 (June 1982): 276-278.

Feibel and Springer investigated the recovery patterns of stroke patients. They pointed out that psychosocial adoption to stroke has only recently begun to receive attention. Specifically, since depression is a common finding in stroke survivors, the researchers examined 91 patients from a group of 124 patients to determine the incidence of depression and characteristics of depression-prone patients. Patient assessments were done by trained, registered nurses. Depression status and the number of social activities in which the patient participated both prior to and after stroke were obtained. Categories for the latter included work, hobbies or sports, past times, community activities and socializing with family and friends. Results indicated that 26% of patients were depressed. At a significant level, 37% of the patients lost 33% or less of their previous activities, 36% lost between 33% and 66%, and the remaining 27% lost more than 66% of their previous activities. Also significant was that depressed patients lost 67% of their prior social activities, while patients whom nurses did not rate as depressed lost only 43% of their prior social activities. Lastly, a strong relationship existed between the nurses' ratings of depression and the patients' own perceptions of their psychological health. This article in summary emphasized the importance of early identification of depression following a stoke.

Kim, Katherine K., "Response Time and Health Care Learning of Elderly Patients". Research in Nursing and Health 9 (1986): 233-239.

A difficult aspect when health care providers care for elderly patients can be their slow behavior. Research has shown that the elderly are slower in responding to environmental stimulation then younger people not only in psychomotor behavior, but also in cognitive functioning. The purpose of this study was to determine if elderly patients performed better in health care learning when provided with slower or self-paced response conditions. The sample consisted of 105 institutionalized elderly people randomly assigned to three response groups: fast paced, slow paced, and self paced. Learning performances of each of the three groups were measured after nutrition instructions were given. The significant result was was that the self paced response condition performed better then the two experiment paced response conditions. Learning performances under the fast and slow paced conditions did not differ. Findings of this study documented that a self-paced response condition was the best teaching mode for elderly patients.

Rheingold, Eleanor Levitan, Buettke Motte, and David R. Mandel, "Learning to Dress: A Fundamental Skill Toward Independence for the Disabled". Rehabilitation Literature 41 (May-April 1980): 72-75.

The authors first pointed out the renewed interest in the clothing needs of the disabled. For this study, the investigators developed an educational shirt series for teaching dressing and undressing skills using a shirt and an instructional manual on the dressing process. The instructional manual consisted of a progressive series of six shirts and was selected because it involved the fundamental movements used in the dressing process. When the individuals succeeded with shirt 6, they would then hopefully be ready to apply the learned skills to nonspecialized clothing. Three groups of five patients were randomly divided. One group (G1) practiced undressing and dressing in the sequence easy to more difficult. A control group (G2) practiced the activity in the reverse order. A second control group (G3) practice unbuttoning and buttoning shirts that were similar in design to the garment used by the above two groups, except for button closure. The sessions were taped and analyzed by the instructor. Task performance analysis showed that G1 exhibited more independence than G2. These participants were more proficient in undressing and dressing skill progressing more rapidly through the difficulty levels and also greater capability of putting on and taking off their own shirts. In summary, the educational shirt series along with the instructional manual proved to be successful teaching tools for teaching the fundamentals of undressing and dressing. It should be noted that once these fundamental skills were learned, the participants were able to apply them to their own garments. The researchers thought that this technique could prove to be a very valuable educational device because it was easy to administer and its rate of success was quite high. The teaching system has the additional benefit of generalizability and reproducible results. Lastly, independence and self-worth were achieved which can spill to other areas of the patient's life as well.

Wade, Derick T., Richard Langton Hewer and Victorine A. Wood, "Stroke: Influence of Patient's Sex and Side of Weakness on Outcome". Archives Physical Medical Rehabilitation 65 (September 1984): 513-516.

This study was conducted to investigate the importance of the side of weakness and sex of the patient in patient outcome after stroke. One hundred sixty-two consecutive acute stroke patients attending a rehabilitation unit participated. Eighty-four patients with right sided weakness were compared with seventy-four patients with left sided weakness on all factors. Patients were categorized by sex; eighty-one in each group. Results suggested that functional recovery was not influenced by the factors investigated as long as measurements were made at set times post stroke. However, patients with right hemiplegia received rehabilitation efforts longer so they appeared to have made a better functional recovery when the ability of daily living activity was measured upon discharge. Although right hemiplegia was associated with aphasia and left hemiplegia with spatial disorder and loss of sitting balance, the associations were not strong enough to affect functional recovery. Sex of the patient had no significant effect upon either the frequency of initial defects or upon outcome, and no obvious interaction between the two variables existed.

Byrne, T. Jean and Dorcas Edeani, "Knowledge of Medical Terminology Among Hospital Patients". Nursing Research 33 (May-June 1984): 178-181.

The purpose of the study was to determine if there continues to be a difference between staff perception of patient knowledge of medical terminology and the actual knowledge of patients in a health care setting. The sample included 125 patients admitted to a medical unit or an out-patient clinic of a 325-bed county general hospital. The hospital was an acute-care medical/surgical facility and patients diagnosed with cardiovascular disease, hypertension, diabetes, cancer or other unclassified medical conditions were in the sample. The ages of the patients ranged from fifteen to eighty-two years. A list of fifty common medical terms was compiled by various medcial staff. The questionnaire consisted of a statement that contained the medical term followed by three respone options. One option was the correct response was described by Taber's Cyclopedic Medical Dictionary.

Results showed that no respondent answered all fifty items correctly, and no one question was correctly answered by all 125 respondents. Scores ranged from four to forty-eight correct answers with the term "autopsy" being most often correctly answered; 120/125. "Mastectomy" was least often correctly answered; 13/125. Overall, this study indicated that there continues to be a need for improvement in patient vocabulary knowledge. The authors concluded that with the conversion of hospitals into acute-care facilites, more responsibility is delegated to the patient. Therefore, patients have to be more informed of their illness before complete compliance with medical regimens can begin.

Higbee, Martin, George Dukes and John Basso, "Patient Recall of Physicain's Prescription Instructions". Hospital Formulary (April 1982): 553-556.

This study showed that assistance was needed to ensure proper use of prescribed medications. Ninety-eight patients (ninety female and eight male) receiving new prescriptions from either the family practice clinic or the pediatric outpatient clinic during a three-month period participated in the study. The subject included persons who took or administered the medications. Interviews were done by pharmacy students. Results indicated that only one knowledge item was found to be significant; the recall of how frequently to take the medication by patients in the pediatric clinic. Few patients or their representatives (38.4%) provided a correct response when asked the name of their prescribed medication. The majority (74.5%) knew the medication's purposes and although 82% knew the proper rate of administration, only 38.8% understood the frequency of administration. A composite score of seven knowledge items indicated the patients recalled an average of only 48% of the information. The conclusion from this study was that without a thorough knowledge on proper drug administration, patients may believe they are complying with the medication regimen while in actuality they are not. He concluded that the pharmacist and other health personnel should not assume the patient or patient's representative adequately understands the proper self-administration techniques for their prescribed medications following a visit to the physician.

Foster, Charlotte McNabb, "The Use of Transactional Analysis in Patient Teaching". Supervisor Nurse (May 1981): 18-23.

This article discussed that there is a growing awareness among health professionals that patients can contribute to the process of their recovery when they are knowledgeable about their conditions. Patient education was defined by health care institutions and agencies by starting with knowledge of health promotion, preventive medicine, informed consent, disability management, and the dying process. Next, transactional analysis was defined and the doctors and nurses were described as the parents and the patients as children. Also, Foster stressed that people learn only when they want to learn. Next, suggestions were outlined for effective teaching. Most importantly, medical professionals should not make patients feel overpowered. Lastly, the authors encouraged that the education of patients be a team effort.

Hopps, Linda, "A case for Patient Teaching". Nursing Times 7 (December 1983): 42-45.

This paper was a case for patient teaching. Hopps argued that instruction was an essential part of patient care stressing that nurses in order to teach effectively must be clear of their aims. She contended that nurses fail to have any specific methods or defined objectives for teaching. She believed that there are two fundamental reasons why teaching was important. First, a substantial amount of evidence as a result of nursing and medical research showed that preoperative teaching improves the psychological status of patients undergoing surgery. Secondly, the instruction enhances the physical outcome. She continued to cite research studies that discussed anxieties, pains, and discharge adjustment at home in relationship to teaching. She ended her paper by challenging her readers with the serious responsibility that teaching is both an individual and collective responsibility. She also noted the minimal research done related to postoperative teaching and discharge planning.

McHugh, Norma G., Norma J. Christman and Jean E. Johnson, "Preparatory Information: What Helps and Why". American Journal of Nursing (May 1982): 780-782.

This article showed by citing research studies why preparing patients for diagnostic or therapeutic procedures helps patients. The authors argued that awareness of how specific information helps patients, the characteristics of that information, and the expected effects on patients' behavior can guide the selection of information that is conveyed to patients. The selection of patients most apt to benefit, and the evaluation of the outcomes. The term schemata was used, which means mental images of former experiences. Several guidelines for giving patients preperatory information were given. They were:

(a) Physcial sensations should be described, but not evaluated,
(b) Patients should be told what causes the sensations, and
(c) Patients should be prepared only for those aspects of the experience that are noticed by the majority of patients.

Petrello, Maj. Judith, "Your Patients Hear You, But Do They Understand". RN (February 1976): 37-39.

Petrello confronted her readers with the statement that "A nurse's casual use of clinical words and abbreviations in conversing with patients usually confuses them and after causes them undue uncertainty and anxiety about their hospital stay." This study was conducted to examine possible misunderstandings and misinterpretations that add to a communication gap between staff and patients. A list of forty words and ten abbreviations were randomly selected. Each term in the list was read in a sentence to 200 hospitalized adult patients who were then asked the meaning of the terms. The results indicated that none of the 200 patients defined all the items correctly; however they identified them all as ones used by nurses in conversation. Correct responses ranged from forty-one percent for patients with four to twelve years of schooling to sixty-eight percent for patients having done gratuate work. This study clearly demonstrated that hospitalized adults do not understand a great many of the terms being employed by nurses in "normal" conversations. The paper concluded with the following three suggestions to make their message clear to patients.

(a) Just being aware that nonprofessionals may completely misunderstand the nurses' words and intentions is a good start.

(b) The nurse's selection of terms should be tailored to the patient's mental and emotional capabilities.

(c) Most important, the nurse in clinical practice should give the patient time to react.

Boyd, Marlyn, "How to Write a Teaching Aid that Patients Will Actually Read". RN (October 1982): 94-95.

This article described how nurse educators can write patient pamphlets that are more effective and economical than commercial literature. It listed and described tips such as: defining the patient population, making sure that the information is clearly written and easy to understand, avoiding medical jargon and statistics, keeping the pamphlet short, setting the most appropriate tone in a positive manner, and presenting material in an interesting manner so that the patient will read it from beginning to end. Content should be decided after questioning patients on topics that they want to know. Writing titles and clever illustrations will help generate interest. Lastly, the effectiveness should be tested by asking patients and nurses to evaluate the pamphlets.

Jones, Patricia and William Oertel, "Developing Patient Teaching Objectives and Techniques: A Self-Instructional Program". Nurse Educator (September - October 1977): 3-18.

In this article Jones and Oertel argued that patient education is best accomplished by setting clear objectives that state in precise, measurable terms what the patient needs to learn. They said that objectives allowed the teacher to:

(a) Determine the most effective teaching techniques,
(b) Provide coordinated patient education, and
(c) Evaluate the patient's progress as a learner.

They reviewed eight principles of patient education. Health education was regarded as an integral part of high quality care. Also, teaching can be used to prevent, promote, maintain, and modify a wide variety of behavior in a receptive individual. Essentially, they stressed that health teaching required determining what a person needs to know, what he is capable of learning, how he can best be be taught, and what he has learned.

Leighton, Audrey Olson, "10 Steps to Better Patient Teaching". RN (October 1976): 76-78.

Leighton emphasized that during patient-nurse teaching sessions, nurses messages too often do not get across. She thought that part of the reason was that nurses and patients do not always agree on what is important. She contended that teaching tactics aimed at subjects both patients and nurses deem important are effective. She listed a ten-step teaching guide to satisfy the goals of both nurses and patients. They were as follows:

(a) Actively attempt to find out what is important to each patient,
(b) Assure patients that you will answer their questions, but stress that it is equally important for them to understand the items you consider important,
(c) Remember that facts are not enough,
(d) Present all your information clearly,
(e) Restate the information,
(f) Correct any misconceptions gently,
(g) Give lists of the topics you cover and write out any explanations you think patients will have difficulty remembering,
(h) If you do not know enough to explain something fully, admit it,
(i) Schedule follow-up discussions to reveiw how well patients carry out your instructions and to cover any additional material if needed, and
(j) Summarize your teachings.

Miller, Ann, "When is the Time Ripe for Teaching". American Journal of Nursing (July 1985): 801-804.

Miller argued that patient education makes a difference. She described the immediate need because of forced shorter hospital stays, increasing demands on available time, and the need to give acutely ill patients highly technical information as quickly as possible. A three step approach to teaching was summarized as follows:

(a) Establishing rapport and reducing anxiety and fear,
(b) Teaching the patient about his illness, treatment plan, and other health matters, and
(c) Overcoming obstacles to behavior change.

Also, suggestions to help patients understand and remember what they hear were as follows:

(a) Speak the patient's language,
(b) Be specific when giving information, especially instructions,
(c) Keep it short,
(d) Place key points up front,
(e) Use verbal headings, and
(f) Repeat.

In addition, guidelines for printed patient education materials were reviewed. They were:

(a) Do not assume that because it is in print, it is accurate,
(b) Make sure teaching tools are geared to the audience receiving them, and
(c) People do not necessarily read at the level of their completed education.

Lastly, questions to ask if health care providers decide to write a pamphlet were listed. They were:

(a) Do patients ask a lot of questions,
(b) Do you frequently find youself repeating this information before patients understand,
(c) Is it information patients must have to perform self-care activities safely, and
(d) Is it information the patients need to troubleshoot problems?

Pavlik, Maureen M., "An Efficient Patient-Teaching Tool". Orthopedic Nursing 2 (January - February 1983): 23-25.

This article included a sample script of a teaching aid "About Your New Knee". Pavlik recommended the aid which consisted of a notebook and photographs to be used with a tape. It was used as a tool when teaching pre-operative patients about their surgery and treatment. The advantages, considerations, preparational steps and a summary were described. Subjective evaluations have been positive, yet one of Pavlik's goals for the future is to evaluate the effectiveness of these aids in a more scientific manner.

Spadero, Daniel C., "Assessing Readability of Patient Information Materials". Pediatric Nursing (July-August 1983): 274-278.

Spadero argued that despite recent attention, many of the booklets, pamphlets and special instructions given to patients are written at an inappropriately high level and not being comprehended by the majority of patients and parents. His goal was for health practitioners to gain a better understanding on readability formulas so that they can apply various formulas to assess and/or prepare written patient materials. In summary, the author compared and recommended several formulas to use for assessing materials for the different reading levels.

Bream, Susan, "Teaching the Elderly About Drugs". Nursing Times 17 (July 1985): 32-34.

Bream investigated a self-medication training program. The goal was to help improve the compliance of elderly patients with drug regimes. The program was carried out on a medical assessment and rehabilitation ward. Many patients were admitted for drug-related problems, therefore, it was deemed suitable. Forty-one subjects completed the trial, twenty of whom were self-medicating. Of these forty-one, seven were male and thirty-four were female. A control group and a self-medicating group were assigned. Patients were asked a list of six questions upon admission, upon discharge, and one week and one month after discharge from the hospital. The self-medicating patients were taught about their drugs in a series of sessions designed for patients. When group scores were compared, results showed that there was a definite improvement in the self-medicating group. Knowledge of the drugs in the self-medicating group indicated marked improvement. At discharge 70% of the self-medicating group gave correct answers for some of their drugs, but it dropped to 52.6% at one month. This, however, is still much better than the control score of 13%. The researcher concluded by stressing the importance of nurses trying to teach elderly patients more about what drugs they are taking; arguing that it was not the sole responsibility of the medical staff. Emphasis must also be put on what is practical in both physical and medical terms for the individual patient.

Hamric, Ann B., "A Teaching Tool for Spinal Cord Injured Patients". Journal of Neurosurgical Nursing 13 (October 1981): 234-238.

A teaching protocal was developed for use on a twenty-nine bed, acute care neurosurgical and orthopedic surgical unit at a large southeastern medical center. The staff responsible for implementing the protocol was very involved in the development. The protocal consisted of nine sections of self care. Content material for each of these sections included: self care importance, and complication prevention, identification, and treatment. Sixty percent of the patients scored eighty percent or higher on a test designed by the author. Patients reacted positively to being taught the material and developed warm relations with the nursing instructors. Nursing staff also reacted positively. The author felt that this tool worked because it was simple. She emphasized that it should be introduced with support and instruction so it is readily accepted and incorporated into staff activity.

Linde, Beverly J. and Nancy M. Janz, "Effect of a Teaching Program on Knowledge and Compliance of Cardiac Patients". Nursing Research 28 (September - October): 282-286.

This study was conducted to assess the effectiveness of a comprehensive teaching program on patient knowledge and compliance. Thirty patients having had valve replacement surgery and eighteen patients having had coronary artery bypass surgery participated. Twenty-five of these patients were taught by masters-prepared clinical specialists and twenty-three by nurses with less than masters preparation. Knowledge and compliance measures were obtained preoperatively, at discharge, and during the first two postoperative visits. Findings included significant changes in knowledge scores between preoperative testing to discharge testing, and stability in most scores between discharge and postoperative visits. Compliance percentages were significantly higher than those reported for cardiac patients in a previous study. Lastly, patients taught by the masters- prepared nurses had significantly higher test scores at discharge than did the patients taught by nurses with less than masters preparation. The investigators believed that the teaching program as well as continuity of personnel involved in follow-up explained the significant compliance rates.

Minton, Patricia Noe, "Video Tape Instructions: An Effective Way to Learn". Rehabilitation Nursing (May-June 1983): 15-17.

Because spinal cord injured patients lose control of their bowel and bladder, it is necessary for patients to participate in a learning process. This study was conducted to determine which of two educational methods was more effective. The methods compared were (a) the use of video tapes followed by discussion, and (b) the use of lecture and visual aids followed by discussion. The study took place at a 180 bed rehabilitation center. Seven patients were in each group. The test contained thirty multiple choice items selected from the class objectives and content outline. Results indicated that both the lecture and video groups had significant gain of knowledge. With the total sample there was a statistically significant positive correlation between the patients' gained scores and their age and educational level. There however, was no significant difference between the amount of learning between the two methods. The study did indicate that video tapes were effective teaching tools with advantages as follows:

(a) Standardization of information assures that the same information is being presented,

(b) Information is disseminated more efficiently in less time than the lectures, and

(c) Availability and opportunity for flexibility in viewing tapes enhances learning.

Nelson, Audrey L. and Brenda Kelley, "Patient and Family Workshops: A New Teaching Approach for Spinal Cord Injury". Rehabilitation Nursing (November - December 1983): 13-16.

Nelson and Kelley described the implementation of a spinal cord injury patient and family training program. Program goals, objectives, schedules, and skills required for passes or discharge were listed. The two day workshop included classes, individual practice sessions, patient and couple sexual counseling, and the use of a discharge check list. The purpose was to educate the patient and caregiver(s) enabling patients to return to their home and community environment more easily. Overall, subjective evaluation reports from the staff, patients, and families have been very positive. Changes have been made based on an undescribed evaluation study. The authors suggested that similar programs could be implemented at other centers where families must travel long distances or where present programs are inadequate or inconsistent.

Pakes, Gary E., "Group Medication Counseling Conducted by a Pharmacist for Severely Disturbed Clients". Hospital & Community Psychiatry 30 (April 1979) 237-238.

Pakes described the need for medication counseling with psychiatric patients in this article. The program has been in existence since 1974 with the classes taking place at a general hospital community mental health center. The group consisted of twenty-five to thirty-five inpatient and partial care clients who met at 1:00 p.m. on Mondays, Wednesdays and Fridays. The meetings usually lasted thirty to forty-five minutes, depending on the seriousness and controversiality of the medication problems. Attendance was recommended for clients having trouble taking medication as prescribed or taking psychotropics at all. One of two clinical pharmacists lead the group on alternate days. The attendance rate at the sessions has remained steady over the last four years with the clients attending eighty to ninety percent of the sessions. Subjective reports indicatd that the program is positive. Lastly, Pakes stressed that the value of the program cannot be overemphasized.

Quinn, Ann, Janet Ford and Mary Mazzawy. "Families and Feelings: A Time for Sharing". Journal of Neurosurgical Nursing, 13 (August 1982): 217-218.

A pilot program for the families of patients receiving intensive and special care was described. Their program provided an opportunity for families to share information and feelings regarding their experiences, concerns, and expectations. Specifics related to the program's implementation were as follows:

(a) weekly meetings for one hour during the 7:00-3:00 shift,
(b) meeting site near the special care area, and
(c) head nurses conducting the sessions.

A number of "filler" topics were utilized to fill in uncomfortable lags. General information such as medical center maps and area dining and lodging facilites were distributed. Participants most readily discussed:

(a) specific patient likes and dislikes,
(b) feelings of comaraderie among the families as a whole,
(c) most stressful experiences for family members, and
(d) what is most and least helpful to family members.

The input from family members resulted in the development of an informative booklet for future participants. The program's success lead to the initiation of family meetings on the evening shift.

Smith, Janet E., "Improving Drug Knowledge in Psychiatric Patients". Journal of Psychiatric Nursing and Mental Health Services (April 1981): 16-18.

Smith briefly explained a process which consisted of interviewing thirty patients one or two days prior to discharge in conjunction with discharge planning. On the basis of the answers given, five patients were able to identify accurate information related to their medication. The remaining twenty-five patients either gave incorrect information or were unable to give any information about their medication. A medication education program was developed as a solution to this problem. The objectives were to:

(a) Provide patient education on the primary actions and side effects of discharge medications,
(b) Provide an opportunity for patients to verbalize their concerns regarding outpatient drug treatment, and
(c) Provide patients with a positive attitude toward complaince with the drug regimen.

Inservice sessions were held to acquaint the nursing staff with the purposes. Patient acceptance of the medication teaching has been excellent according to Smith. Most patients have been receptive to learning.

Whiteside, Sharon E.,"Patient Education;Effectiveness of Medication Programs for Psychiatric Patients''. JPNMHS. 21 (October 1983):16-20.

Whiteside's intent of this study was to determine if a structured patient education program that included written reinforcements would statistically document an increase in patient knowledge with medical as well as psychiatric diagnoses. The subjects included twenty-eight psychiatric patients who attended a cardiology clinic at a veterans administration medical center. Nurses recorded patients' diagnoses and current drug therapy. All participants were privately questioned regarding their medications. They were seen by the physician and those in the patient education group were seen again by the nurse for follow-up teaching. Four weeks later, all subjects were asked the same five questions regarding their medications. Results showed significant improvements from pre-test to post-test with the patients in the education group. The control group, however, had no significant improvement on any of the questions.

Berni, Rosemarian and Clyde Nicholson, "The POR as a Tool in Rehabilitation and Patient Teaching". Nursing Clinics of North America 9 (June 1974): 265-270.

This was a case example that illustrated how the system of problem oriented charting was utilized in patient teaching. It was initially used by a nurse, yet can be utilized by many members of the rehabilitation team. The article included figures that contained a problem list, clinical records, initial and follow-up progress notes, and flow sheets to demonstrate the facilitation of the documentation and communication process. Problems in the development and maintenance of the POR were cited as stemming from lack of staff education, incentive and/or expertise. Suggestions to correct the difficulies were noted. It was the opinion of these authors that this tool could be incorporated into a teaching program in a rehabilitation setting.

Dunn, Sally A., Carol D. Nelson and Paula M. Peterson. "An Education About Stroke". Rehabilitation Nursing, (September-October 1984): 27-29.

The authors emphasized the importance of a team effort when assisting stroke patients to achieve their optimal level of independence. A significant componenet of rehabilitation was identified as teaching. The theory that family involvement is necessary for the rehabiliation process to be effective was reinforced. Specifically, education:

(a) ensures effective family participation in the rehabilitation process;
(b) decreaes anxiety related to previous misconceptions about stroke; and
(c) effectively maintains or increases the level of independence made by the patient while at the rehabilitation center.

The article continued by describing the development and implementation of an educational program. After an evaluation critiquing the four years of practice, the authors were able to list their program's strongest and weakest areas. In the fourteen month period since the format changed to one two-hour session, eleven classes have been held. Total attendance has been one hundred seventeen family members and sixteen patients for an average attence of 12.09 per session. This compared to an average attendance of 6.8 at sessions before this. Therefore, the revised plan to a monthly two-hour session has increased attendance. The plan has met the needs of patients and their families more efficiently and with more continuity according to these authors.

Kisly, Cathryn. "Striking Back at Stroke". Hospital, J.A.H.A., (November 1973): 64-72.

Kisly described the introduction of a program for stroke patients and their families consisting of a series of meetings. The main objectives were: (a) to provide an educational experience; and (b) to provide a supportive experience. With this approach the program enhanced the effectiveness of rehabilitative attempts to cope with the results of stroke. She explained that the model could be adapted for use by other general hospitals or heart association units. Goals stemming from the objectives were (a) to motivate patients and families to accept the rehabilitation program, (b) to increase understanding of stroke by patients and families, (c) to develop group cohesion for mutual sharing, and (d) to evaluate the program through the ongoing follow-up of discharged patients. One outcome that resulted from the evaluations was that persons suggested that it would be helpful to have an initial meeting in which group members ventilated their feelings. Then, topics such as medical information, the rehabilitation team and discharge planning were discussed. It was believed that the first meeting enabled members to benefit more fully from the series.

Masset, Evelyn, "Establishing a Stroke Cluster in a Skilled Nursing Facility". Rehabilitation Nursing (May-June 1981): 19-21.

Masset described the development of a "stroke cluster" in an Institute for Geriatric Care. In September 1976, six patients with the diagnosis of cerebral vascular accident (CVA) were moved to one area of the Institute. The nursing faculty was skilled with a capacity for 527 patients. The author's and institute's experience indicated that patients observe, learn from each other, and compete with each other in activities. The department of nursing instituted the pilot program with the assumption that patients with CVA's would benefit when grouped together, and that measures could be instituted to expediate their rehabilitation. Five nursing care goals existed:

(a) Establish a bowel and bladder control program,
(b) Promote good sitting posture and balance,
(c) Teach the patients to use their wheelchairs, but only as needed,
(d) Attempt to normalize a patient's lifestyle as soon as possible, and
(e) Establish daily rest periods.

Interestingly, soon after the stroke cluster was established, a patient's family became involved, meeting with the health care team on an informal basis. Then weekly meetings to provide counseling and education were scheduled. Families had an opportunity to "sound off" and verbalize their complaints. They also then expressed their problems in coping and asked many questions. Resulting after the institution of the stroke cluster the following observations were:

(a) The need for a method to evaluate self-care activities on the unit
(b) The need for a methodical data and record system, in addition to the general mandatory charting system, and
(c) A renewed interest and change of attitude in staff was observed.

Consequently, they have designed a nursing self-care evaluation form, kept better records and aimed to initiate a multidisciplinary approach.

Passarella, Phyllis M., "Integration of Nursing and Therapy: An Educational Approach". Rehabilitaion Nursing (November - December 1983): 32-35.

The purpose of this article was to review the steps that nurses in one rehabilitation facility took to promote integration of nursing and therapy. The focus was on the care of the stroke patient in order to update their approaches and improve the continuity of care. The facility was a 200-bed rehabilitation center. A schematic representation of the method was included. The stages of this method were grouped according to the steps of the nursing process: assessment, planning, implementation and evaluation.

Evaluation of the integration and training sessions resulted in several problem solving sessions during the first month. These sessions were held on the units with input from both nurses and therapists. A task force reviewed the project and the evaluation revealed that the staff, as a whole, demonstrated a positive attitude toward this new approach.

Taylor, Maida and Vlasta E. Hajek, "Self-Medication on a Rehabilitation Unit". Archives of Physical Medical Rehabilitation 65 (October 1984): 612-613.

A self-medication program was designed and implemented as part of a multidisciplinary approach to rehabilitation. The basic objectives of the program were:

(a) To teach patient skills required for independent living; the ability to self-administer medication, and the understanding of the importance of both the medication and the adherence to a treatment plan, and

(b) To provide the opportunity through self-medication to develop patient motivation for improvement, thus promoting a sense of responsibility and self-reliance.

The four stages of the program coordinated by a pharmacist were:

(a) patient assessment and introduction,

(b) self-medication at the bedside,

(c) self medication at the nursing station, and

(d) discharge assessment.

Twenty-four patients, representing fifty-two percent of the patients introduced into the program, successfully completed all stages. Severe physical impariment was not usually a deterrent to the program's completion. All patients benefitted from the program by acquiring some skills in self-medication and by receiving additional motivation for improvement. Conclusions drawn from the program were as follows:

(a) The failure rate of about forty percent was attributed mainly to memory impairment and the development of additional medical problems.

(b) Age and physical impairment were not significant factors in the failure rate.

(c) Day-to-day involvement of the clinical pharmacist was essential for the program's success.

(d) Presence of the pharmacist provided additional expertise to the rehabilitation team.

(e) The program has enjoyed widespread acceptance and has become a standard procedure on the rehabilitation unit.

American Heart Association - Indiana Affiliate, Inc. 1983 Audio-Visual Catalog. Film Library, 222 South Downey Avenue, Indianapolis, IN 46219.

This was a catalog of the audio-visual materials available by the American Heart Association. As a public service, 16mm films, film strips, slides, cassettes and video tapes related to cardiovascular disease are offered without charge. The table of contents included: American Heart Associaiton, Cardiopulmonary Resuscitation, Heart Fund Campaign, High Blood Pressure, Nutrition, Professional, and Schools and Public Education. Descriptions of the material's content were given.

National Stroke Association, "Be Stroke Smart". 1420 Ogden Street, Denver, Colorado 80218, 1-303-839-1992.

This was a stroke instructional series that was made possible by the National Stroke Association through a grant from Philip Morris Incorporated. The range of topics was numerous. The hand-outs filed in one folder had the following titles: What is a Stroke?; Stroke: A Main Course of Death Surrounded by Myths; Prison Without Walls; Household Barriers Confronting the Stroke Survivor; Therapy and Long-Term Care in Storke Recovery Activities of Daily Living; The Importance of Proper Diet After Stroke; Suggestions for Communicatory with the Right Hemisphere Damaged Patient (also ... Left Hemisphere ...); Positioning the Stroke Survivor with Paralysis; Suggestions for Effective Communication with the Aphasic Patient; What Every Family Should Know About Stroke; Overcoming the Stroke Syndrome; Depression: A Natural Reaction to Stroke; Returning to Work After a Stroke; Therapeutic Recreation; Use of Braces to Help Regain Control of the Foot/Ankle; Self-Help Devices for the Kitchen; One-Handed Activities; Bladder Problems Following Stroke; and, There is Sex After Stroke.

Also listed in the folder were the following statistics: One out of every ten families is somehow touched by stroke; one out of every five Americans will suffer stroke in their lifetime; two-thirds of all stroke victims will survive; and, through proper care and rehabilitation, most stroke survivors can return home to resume their lives.

SUMMARY

Williamson and Berni agreed that health care givers should understand the neurological aspects of brain damage, such as strokes. Zinn specifically described assessment and management techniques of patients with strokes. He emphasized that a stroke does not only lead to the loss of one half of the body, but of numerous further functions. He considered the loss of sensation or perception as probably the most significant. Burt, also emphasized the perceptual problems of the stroke patient.

Louis and Povse contended that aphasia and endurance were the major negative outcomes of a stoke. Piotrowski's concentration was on psychosocial needs such as body image. She argued that a change in body image is often difficult to accept. This is because the alteration is rapid, unexpected, uncontrollable, and unwanted.

Delisa, Miller, Melnick and Mikulic placed emphasis on the outcomes that can be expected from the rehabilitation process and on the selection of patients for comprehensive rehabilitation. They strongly believed that all stroke patients with any deficits should undergo a rehabilitation evaluation (although an intensive, multidisciplinary team approach is not cost effective in some cases). Lastly, Gresham linked the goals of rehabilitation medicine with the purposes of geriatric medicine. This was especially relevant because most stroke patients are also geriatric patients.

Next, medical and nursing treatment of stroke patients was described. Stryker's book was particularly designed to help nurses implement rehabilitative steps in acute and long-term care. Kaplan and Cerullo provided numerous approaches to use with patients with comprehension and expression deficits. G. Wright's detailed textbook covered the complex process of overcoming a handicap through comprehensive vocational and life adjustment

services to disabled or disadvantaged individuals. The Core Curriculum was an "an initial step in the awareness of the rehabilitation nurse's tomorrow." (Rehabilitation Nursing Institute: Introduction) The Association of Rehabilitation Nurses set as its goal "the collection in a written document of the information and experience considered to be the care of knowledge related to rehabilitation nursing." (Rehabilitation Nursing Institute: Introduction)

Delisa, Mikulic, Melnick and Miller noted that return of neurologic function after a stroke tends to be complete within six months after the onset. Natural recovery after this point is rare, although function may continue to improve with additional training. The importance of assessment and planning for discharge from the patient's admission was emphasized. Participation in a rehabilitation program was encouraged as long as the patient continued to show progress or had not reached a long-term plateau.

Richardson provided an overview of the brain's functions and described the hemisphere's separate functions. She also made suggestions for working with staff to promote empathy for the stroke patient who presents with behavior problems. Bobath described the physical effects of a stroke on a patient. She discussed how the treatment of hemiplegic patients cannot be standardized. She provided basic principles of treatment, yet stressed that every patient is different.

Hart, using a nursing perspective, described in a concise and clear form the basis for which intelligent care of the stroke patient may be provided. Norman and Baratz attempted to further understand aphasia and describe implications for nursing care. Wallhagen described the functions of the left and right hemispheres and then gave specific care plans related to their treatment. Information on the nomenclature of nursing diagnoses was presented by Tilton and Maloof. Their method provided a precise and consistent means of

communicating and documenting the problems that nurses can manage.

Holistic needs were identified by several persons. For instance, Acton looked at the world's response to disability as an evolution of a philosphy. His speech was significant because it was a major meeting at the convention of physical nad medical rehabilitation. Acton's conviction, hope and intention was that a more general comprehension of the realities of the situation would generate a more adequate response.

Zola, a disabled person, presented his paper at a plenary session at the Annual Session of the American Congress of Rehabilitation. He argued that "as a result of our collective past, those of us with a disability spend much of our time in a continuing effort to reclaim what we have lost - the right to act sexy, get angry, be vulnerable, and have possibilities."

Russell detailed the adjustments related to having a disability. He suggested that those approaches dealing explicitely with the person's integration with their environment are the most productive. He concluded by noting that our understanding of what it means to adjust to a disability will recognize multiple forms and levels of adjustment. These, in turn, will vary according to the person's psychological make-up and his or her social and physical situation.

Steger believed that rehabilitation care typically requires a holistic approach to patients and an understanding of the psychological and social factors that influence them, their disability, and the rehabilitation process. He related how the sudden onset of a severe physical disability is a life crisis with great psychological impact. He compared the psychological task of confronting a disability to that of coping with certain impending death or with the death of a loved one.

B. Wright attempted to demonstrate a basic principle which was that positive attitudes are based on constructive views of life with a disability. She contended that to acquire those views requires being exposed to those views through information and direct experience. Carlson highlighted some of the factors that contribute to the uniqueness of the psychosocial aspects of neurologic conditions. Philosophic considerations of the quality of life for the disabled was examined and questioned by Kottke. The importance of increased communication between disabled clients and counselors was discussed by Makas. Chesterman described a stroke patient's needs and how they were met in rehabilitation by the use of a case study. Clark, a previous cardiac nurse, identified needs from a personal perspective as a result of having a stroke herself.

Specific needs of stroke survivors have been investigated by several researchers. For example, Davidson and Young examined problems that stroke patients experience after rehabilitation and how they perceive and interact with their environment. Belcher, Clowers, Cabanayan and Fordyce showed higher levels of participation in performing personal care, home management and social interaction with single persons as opposed to married individuals after stroke.

Variation in the expression of and desire for social support appears to be related to the outcome of rehabilitation and adjustment to chronic physical limitations according to Evans and Northwood. Feibel and Springer were concerned with depression. They argued that the health care team must carefully identify, monitor and manage depression in the patient recovering from stroke. They noted that the depression which is common after a stroke is also associated with failure of the patient to return to previous activities. Also, Bray, DeFrank and Wolfe's study indicated that although the majority of stroke survivors maintain consistent levels of sexual desire and believe that

sexual function is important most will experience sexual dysfunction following a stroke.

The stresses of being a patient were investigated by Davies and Peters. They significantly showed that patients and nurses identified similar stressful items. This finding was interpreted as their sharing common stereotypes about the hospital situation. When elderly patients are to learn, Kim documented that a self-paced response condition was advantageous. The results of Cable and Mayers indicated that with the onset of discharge planning, the length of stay increased for some diagnoses and decreased for others at each hospital. In particular, the stay at a hospital for stroke patients decreased.

Petrello's study demonstrated that hospitalized adults do not understand a great many of the terms being used by nurses in "normal" conversations. Such communication blocks impede mutual understanding and can cause confusion , anxiety and even antagonism between the patient and nurse. However, Byrne and Edeani pointed out that there has been an improvement in patient knowledge.

Foster argued that patients contribute to the process of their recovery when they are knowledgeable about their conditions. McHugh, Christman and Johnson gave the reasons why specific information helps patients and furnished guidelines for selecting that information. Regarding patient instruction, Miller stressed that health care providers must make patient education as productive as it can be.

The methods of patient teaching were then examined. Jones and Oertel emphasized that patient education is best accomplished by setting clear objectives that state in precise, measurable terms what the patient needs to learn. Hopps emphasized that teaching is an essential part of patient care. Also, she thought that for nurses to teach effectively, they must be clear of their aims. Leighton gave ten steps to better patient teaching.

Spadero shows how practioners can apply objective readability formulas to assess and/or prepare written patient education materials. Boyd argued that by investing a little time and following a few basic guidelines, patient pamphlets could be written more effectively. Next, Pavlik offered an aid that was a notebook with photographs and a tape.

Medication teaching programs for non-stroke patients was the most frequent. For instance, Higbee, Dukes and Basso demonstrated that subjects did not adequately recall prescription instructions given during their clinic or office visit. Bream explained a program that helped improve the compliance of elderly patients with drug regimes. Pakes, Smith and Whiteside described medication sessions for psychiatric patients.

Linde and Janz described the impact that staff nurses and masters-prepared nurses had on patients who were on a cardiac unit. Using instructional materials related to bowel and bladder management of a spinal cord injured (SCI) patient, Minton found significant gains of knowledge in patients who were taught by lecture and discussion method and to videotapes and discussions. Hamric, Nelson and Kelley discussed a protocol and workshop that also can be used as a teaching tool for SCI patients. Quinn, Ford and Mazzawy described a pilot program for a family support group in the intensive care unit.

Dunn, Nelson and Peterson stressed that for rehabilitation to be effective, the family as well as the patient must be involved. They contended that if they are not involved and informed, family members will not be prepared to deal with the demands of the stroke patient. Kisly summarized that a stroke family education program can enhance the effectiveness of medical and other approaches to rehabilitation of stroke patients.

The development of a stroke cluster in a geriatric institute was described by Masset. Passarella described the steps that nurses in one rehabilitation

facility took to promote integration of nursing and therapy in the care of stroke patients. Berni and Nicholson believed that problem-oriented records can be developed into useful tools for patient teaching and can be utilized by the members of the rehabilitation team. A self medication program for rehabilitation patients was described by Taylor and Hajek. Next, the American Heart Association listed available audio-visual learning materials for staff, patients, and families. Finally, The National Stroke Association provided a folder entitled "Be Stroke Smart" for stroke patients and their families.

CONCLUSIONS

There were several conclusions arrived at from this study.

First, thorough assessments of stroke patients was found to be essential and beneficial to the patient, family and interdisciplinary team. Alterations, changes and negative outcomes resulted after the stroke. All stroke patients with any deficits should undergo a rehabilitation evaluation if it is cost effective. (Delisa, Miller, Melnick, and Mikulic)

Encouragement of participation in a rehabilitation program is necessary as long as the patient continues to show progress or has not reached a long-term plateau. (Delisa, Mikulic, Melnick and Miller) Implications specifically for care for nurses were provided. (Richardson, Hart, Norman and Baratz, Wallhagen, Tilton and Maloof)

The philosophy that a stroke patient has holistic needs is a very important one in rehabilitation. (Acton, Zola, Ryssell, Steger, B. Wright and Kottke) It is also important to note that strokes affect patients at a very personal and emotional level. (Chesterman and Clark)

There are specific needs that should be identified during rehabilitation which need to be identified and treated by healthcare givers. (Davidson, Young, Belcher, Clowers, Evans and Northwood, Feibel and Springer, Bray, DeFrank and Wolfe, and Davies and Peters)

In addition, there has been an improvement in patient knowledge concerning their care. However, a gap still exists between the information related by the healthcare givers and the patient's understanding of the information given. (Byrne, McNabb-Foster, McHugh, Christman and Johnson, and Miller)

Methods and guidelines for teaching are beginning to pave the way for the development of stroke education programs. (Jones and Oertel, Hopps, Spadero, and Boyd)

Medication programs have been proven to work effectively in improving patient compliance. (Higbee, Dukes and Basso, and Bream) Effective teaching programs have also been documented with cardiac and spinal cord populations. (Linde and Janz, Nelson and Kelley, and Taylor)

The need for stroke rehabilitation has increased due to an increase in stroke survivors. Although the patient and the patient's family should be highly encouraged to participate in educational and supportive programs, there are very few articles in the literature that describe the implementation of such educational stroke programs. (Dunn, Nelson and Peterson, and Kisly)

RECOMMENDATIONS

It is recommended that more comprehensive psychosocial educational programs be developed. Critical components of the program should include:

(a) Patient and family teaching should begin upon admission to a hospital setting or, if not, at the time of entry to a rehabilitation setting.

(b) Healthcare givers should respond openly, honestly and knowledgeably to the questions of patient and family. This is so their extensive needs will be met and complications avoided.

(c) Healthcare givers should work as an interdisciplinary team.

(d) Healthcare givers should receive current instruction related to strokes in their professional preparation and development. In particular, specific methods of dealing with grieving for the patient and family should be included. They should be encouraged to take certification examinations in their specific interest area.

(e) Healthcare givers should become more familiar with local and national referral agencies and organizations.

(f) Healthcare givers should begin developing discharge teaching check-off lists, such as that included in appendix one.

(g) Objective outcomes and valid tools such as evaluation forms, tests, and questionnaires should be used to evaluate the teaching program's effectiveness.

(h) A resource library containing books and pamphlets related to strokes available to families on a check-out basis should be developed.

(i) Films or videotapes should be viewed to assess if they can be used as teaching tools for patient and families.

(j) Healthcare givers should be given opportunities to verbalize their own feelings and frustrations related to caring for those persons with strokes on a regular basis.

(k) Research efforts are greatly encouraged to continue building the theoretical foundation required to establish and maintain a comprehensive stroke educational program.

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APPENDIX

MICHIANA REHABILITATION INSTITUTE
STROKE TEACHING CHECK-OFF LIST

INITIALS	NAME/TITLE	INITIALS	NAME/TITLE	INITIALS	NAME/TITLE

TOPIC	INITIATED	COMPLETED	COMMENTS/PAMPHLETS GIVEN
REHABILITATION ORIENTATION (REC/HN)			
EQUIPMENT NEEDS/USE (OT, PT, REC, NURSING)			
BED MOBILITY (PT)			
BASIC TRANSFERS (PT)			
POSITIONING (PT)			
WHEELCHAIR USE (PT)			
SAFETY PRECAUTIONS (NURSING)			
STROKE ETIOLOGIES, PREVENTION, TREATMENT (NURSING, PHYSICIAN)			
OTHER DIAGNOSES (NURSING)			
FIRST LOA PREPARATION (NURSING, PT, OT, REC, SS)			
MEDICATIONS (NURSING)			
LEISURE ADAPTIVE EQUIPMENT (REC)			
LEISURE RESOURCE INFORMATION (REC)			
LEISURE RESOURCE FILM INFORMATION (REC)			

APPENDIX (Continued)

TOPIC	INITIATED	COMPLETED	COMMENTS/PAMPHLETS GIVEN
SEXUALITY (SS)			
COMMUNITY RESOURCES (SS)			
COMMUNITY RE-ENTRY AND REFERRAL (SS, REC)			
COPING STRATEGIES (SS)			
ORAL CARE/NUTRITION (NURSING, OT, DIETICIAN)			
SKIN CARE (NURSING)			
BOWEL PROGRAM (NURSING)			
BLADDER MANAGEMENT (NURSING)			
SLEEP PATTERNS (NURSING)			
HOME MODIFICATION CONSULT (OT)			
LANGUAGE/COGNITION (ST)			
HOME PROGRAM (OT)			
HOME PROGRAM (PT)			
HOME PROGRAM (ST)			
VOCATIONAL TESTING (OT)			
HOME HEALTH REFERRAL (NURSING)			
DRIVERS EVALUATION (NURSING)			
OTHER:			

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